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Lost in Translation: Social Workers' Perceptions of the Benefits and Challenges of
Spoken Language Interpretation in Medical Settings

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MSW 682 Project Plan

Presented to the Faculty of the
School of Social Work
St. Catherine University and the University of St. Thomas
St. Paul, Minnesota
in Partial fulfillment of the Requirements for the Degree of

Master of Social Work

Committee Members

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The Clinical Research Project is a graduation requirement for MSW students at St. Catherine University/University of St. Thomas School of Social Work in St. Paul, Minnesota and is conducted within a nine-month time frame to demonstrate facility with basic social research methods. Students must independently conceptualize a research problem, formulate a research design that is approved by a research committee and the university Institutional Review Board, implement the project, and publicly present the findings of the study. This project is neither a Master's thesis nor a dissertation.

Abstract

With the increasing number of foreign born individuals in the United States, the usage of spoken language interpretation is also increasing in order to provide equal and quality services for patients with limited English proficiency. Understanding the dynamics of working with interpretation is important in order to achieve best practice for social workers. The purpose of this study is to explore the social workers' perception of spoken language interpretation use in a medical setting. The study examines the amount of interpretation usage and the different type of interpretation usage. The study also explores the satisfaction of the interpretations' performance in sessions from a social workers' perspective. A total of 46 social workers completed the research study survey. The survey consisted of both quantitative and qualitative questions. The study found that in-person interpretation is the most utilized and is perceived to have the best satisfaction. Patients' family members and friends were also found to be widely utilized as interpreters. However, this usage is mostly due to patients' wishes or lack of professional spoken language interpretation for the situation. The study found several important implications for social work practice, policy, and future research. The results suggest that the social worker profession needs to receive more education around working with interpretation in order to provide quality services and fulfill ethical standards. The results also suggests need to establish standard policies for spoken language interpretation services. Suggestions for future research are also provided in the paper.

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The 2010 census estimated the number of foreign born individuals to be around 40 million, 13 percent of the total population of the United States (Bhaskar, Arenas-Germosen, Dick, 2013). The census also indicated that 85 percent of the foreign-born population spoke a language other than English at home, and one in ten foreign born did not speak English at all. In the United States, individuals who are not fluent in English are referred to as “language minority” individuals (Casado, Hegi, & Hong, 2012). The state of Minnesota’s foreign-born population is actually increasing faster than the national average, and about 404,000 (7.3%) residents of Minnesota are foreign born, including many refugees who fled their home countries.

Despite the increased number of foreign-born people in Minnesota, there is a lack of ethnic minority social workers. In 2013, out of the total 3,435 licensed independent clinical social workers (LICSW), only 147 (4.3%) of LICSW self-identified as an ethnic minorities (Wilcoxon et al., 2013). Three percent of the Minnesota population reported as Hispanic of origin, but only 0.75% of all licensed social workers reported to be Hispanic of origin (Wilcoxon et al., 2013). There is a huge disparity according to the data and this is an underserved population of great concerns. In Minnesota, it is required for government agencies to provide an interpreter to language minorities, but interpretation could add another barrier for the communication. Patients reported to be more comfortable working with social workers or staff that speak their own language, and report a higher rate of satisfaction for services (Ng, Popova, Yau, and Sulman, 2007). Even if agencies provide adequate interpreter and culture services there is still a barrier for language minorities to access services.

Understanding the language barrier faced by this population is important because the ability to speak and understand English greatly affects how well people communicate and navigate through different social institutions and system. A person’s lack of English proficiency

is commonly translated into a personal choice in social relations and devalues their other language competencies (Harrison, 2007). Lack of English proficiency often becomes a barrier for language minorities to access necessary treatments and services. According to Ponce, Hays, & Cunningham (2006), programs that do not incorporate the needs of language minorities result in poorer quality of care and health disparities. It is important for social work professionals to understand the health services need of this population, since it is a vital component in reducing the gap in access to quality health care services. Even with the increasing use of spoken language interpreters in health care settings, there is a lack of research on the quality of services they are providing. A 2015 Minnesota Department of Health (MDH, 2015) recommendation report for interpreters in health care settings highlighted the lack of specified qualifications and standards for interpreters. The State of Minnesota does not have any guidelines or requirements for interpreters who work in health care settings. The lack of standards could result in poor services and create additional barriers for the clients and providers.

There is also a lack of research and knowledge in regard to social workers working with interpreters in the health care system. This research study was conducted in order for social workers in medical settings to better understand the needs or barriers that language minorities might face. With the limited literature on this topic, there are a couple key components that could help us understand more in regard to the social workers working with language minorities. By studying the experiences and perspectives of these social workers who work with the results can help build a better perspective on working with language minorities. This research study will examine the experiences of social workers working with interpreters in a medical setting to gain more insight on the social workers' positive experiences and the challenges they encounter.

Literature Review

From the 2010 census, the estimated number of foreign born people in the United States was around 40 million, 13 percent of the total population (Bhaskar, Arenas-Germosen, Dick, 2013). It is estimated about 404,000 (7.3%) residents of Minnesota are foreign born, including many refugees who fled their home countries. Nearly one in six children (0-19) in Minnesota has at least one immigrant parent. Even though the state of Minnesota still has proportionally fewer immigrants than the United States as a whole, Minnesota's foreign-born population is actually increasing faster than the national average (Minnesota Compass, 2014). Minnesota has a rich history of immigrants, beginning with the Hmong population who migrated to the Twin Cities starting in 1970s, Minnesota continues to experiences growth in immigrants and foreign populations. Much of the foreign born population comes from less developed countries, and many have lived in refugee camps for many of years before coming to the United States. Many foreign born residents speak another language other than English; Out of the Minnesota foreign born population, around 20% of the Minnesota residents reported "do not speak English," or "speak English, but not well." Many of the immigrants and refugees also did not have a chance to receive a proper education; around 20% of the foreign born population in Minnesota only completed high school or received GED, and 25% of the foreign population did not complete high school, compared to 6% of native born Minnesota residents with less than a high school education (Minnesota Compass, 2014). Low education levels lead to undesirable/ minimum wage jobs, and a greater likelihood of living in poverty. In 2013, around 20% of foreign born population lived below the federal poverty level, and 12% of Minnesota residents living below poverty level were foreign born (Minnesota Compass, 2014). Many immigrants also lack an understanding of U.S. medical systems and insurance policies. The Minnesota Compass data is

compiled from the U.S. Census Bureau's Decennial Census and American Community Survey. There are still many undocumented or unreported immigrants living in Minnesota that were unaccounted for in this discussion.

The increased number of foreign born residents in Minnesota led to an increase in cultural diversity and languages spoken in Minnesota. With 20% of the foreign born population reporting "do not speak English," or "speak English, but not well," there is a need of diverse social workers. Despite the increasing foreign-born population in Minnesota, there is a lack of ethnic minority social workers to reflect the growth of the state's ethnic population. In the 2008 Legislative Mandated report, The Board of Social Work documented a total of 10,436 licenses social worker (LSW, LGSW, LISW, LICSW) in Minnesota. Out of the total number of licensed social workers, 487 (4.6%) self-identified as a minority ethnic group and 50 percent of this ethnic minority identified as African American (Wilcoxon et al., 2008). Comparing the number of licensed social workers who identify themselves from a minority ethnic group to percentages of the minority population, there is an easily observed disparity. In 2008, out of the total 3,435 licensed independent clinical social workers (LICSW), only 147 (4.3%) of LICSW self-reported to identify as an ethnic minority (Wilcoxon et al., 2008). Three percent of the Minnesota population reported as Hispanic of origin, but only 0.75% of all licensed social workers reported to be Hispanic of origin (Wilcoxon et al., 2008). There is a huge disparity according to the data and this is an underserved population of great concerns. The service providers and the patients/clients are coming from different cultural and language backgrounds, thus often leading to patients/clients facing challenges from a white-culture dominated system.

Language Barrier Effects in Healthcare

Numerous studies have examined the influences of limited English language proficiency on access to health care, and identified multiple consequences of language barriers. Patients with limited English proficiency (LEP) often experience difficulty communicating with medical providers and rate their health care experiences more negatively. LEP patients also experience worse access to care, including obtaining health insurance, medical care, physician visits, and preventive services (Shi, Lebrun, & Tsai, 2009). LEP Patients reported facing different challenges with language barriers at both primary and acute care settings. In primary care settings, patients with limited English proficiency are less likely to report to have a regular source of care, continuity of care, more likely to have long waits in the waiting room, and have more difficulty obtaining information or advice over the telephone compared to English-proficient patients (Pippins et al, 2007). Similar barriers also exist in acute care settings; patients with limited English proficiency experience more difficulty obtaining care, diagnostic testing, utilizing resources, and lower satisfaction with care (Carrasquillo et al., 1999). Providers expressed that their discussions with LEP patients are less patient-centered; in cancer care settings the providers often need to simplify the discussion of risks and benefits and be more directive with regard to treatment options and recommendations (Karliner, Hwang, Nickleach, & Kaplan, 2011). The language minority clients often face more obstacles than their English speaking counterparts. Without the proper English skills, language minorities lack the education on related information, and also struggle more than English speakers while working through unfamiliar systems.

In the current healthcare system, the LEP patients often encounter an immediate power-based disadvantage given their possible lack of medical knowledge, but then are even further disempowered by their limited English proficiency. The healthcare system poses additional

challenges to LEP patients and healthcare providers. Providers reported the lack of notification that a patient is LEP prior to the clinical encounter often creates additional stress and challenges to the healthcare providers (Michalec, Maiden, Ortiz, Bell, & Ehrenthal, 2015). Providers reported they were often unaware that a patient was non-English speaking until they entered the room, thus leading to the providers having to arrange an interpreter at the last minute. This situation often led to longer wait time for patients and less satisfaction from patients with the care (Michalec et al., 2015). Providers have expressed the stress of working with LEP patients when the provider-to-patient ratio was already high; providers reported having negative attitudes and difficulty providing quality care to LEP patients when there are no advance notification while carrying a heavy patients load (Michalec et al., 2015). The healthcare system affects LEP patients' willingness to seek care but could also enhance providers' frustration and negative attitudes toward LEP patients. The communication barriers and negative attitudes from providers also lead to poor rapport building between the providers and LEP patients.

Effect of Language Barrier in Social Work Practice

When working with LEP clients who speaks a different language than the social worker, the experiences are often challenging for both the social worker and the clients. When the social workers and their clients speak two different languages, it is often more difficult for them to form and build relationships. Studies have found that minority ethnic families are treated more poorly than families with majority language proficiency by the social service system (Chand, 2005). Effective communication between the social workers and the clients is essential since the communication helps bridge the understanding and connection between the clients and social workers. Social workers rely on the information communicated by the clients to analyze the situation, assess potential problems, and assist the clients with their needs. Without effective and

proper communication, the language barrier could hinder social workers' performances (Kriz & Skivenes, 2010). Clients with limited English proficiency also received less services or treatment options than their English speaking counterparts, since certain services might only be available in English. Studies found that some social workers reported challenges when referring LEP clients, since there were less options, availabilities, or even no services available in client's native language (Chand, 2005; Kriz & Skivenes, 2010). In order for social workers to provide adequate services, interpreters are often required during meeting with LEP clients. Interpreters often provide more than translating the language; they can provide important cultural and contextual information which may have significant bearing on the issues being discussed (Tribe & Lane, 2009). Often time, the LEP clients came from a different cultural background than the social worker. The knowledge of a language makes communication possible for social workers, but it is their understanding of a culture that grounds the interaction with their clients (Engstrom & Min, 2004). A study with bilingual social workers reported it is easier for social workers to build relationships and for their clients to trust them, since they speak their language and understand their culture (Engstrom & Min, 2004). Interpreters are the key component in helping social workers work with LEP clients, but the process of interpretation often brings on additional challenges that negatively affect the quality of social work.

Interpretation in Minnesota

In February 2015, the Minnesota Department of Health (MDH) presented a recommendation report to the Minnesota Legislature around the current findings about interpreters in health care settings. The report recommended that the Minnesota Legislature establish standards for health care interpreting. Title VI of the Civil Rights Act of 1964 prohibits discrimination on the basis of race, color, and national origin in programs and activities receiving

federal financial assistance (Minnesota Department of Health [MDH], 2015). The Act requires medical providers receiving federal assistance to make interpretation services available to LEP patients free of charge. Currently, Minnesota law does not have minimum standards for healthcare interpreters, though there is a spoken language health care interpreter's roster to which MDH encourages interpreters to register. There is a \$50 annual roster fee, but there are no requirements which need to be met to be listed on the roster. As of December 1, 2014, there were approximately 3,600 interpreters on the roster.

Interpretation may be provided in-person or remotely. In-person interpretation is where the interpreter, patient, and provider are in the same room. Remote interpretation occurs when the interpreter is not in the same room as the patient and provider. Remote interpretation traditionally occurs over the telephone, with interpreter on one end, and the patient and provider on the other. Phone interpretation is still prevalent for remote interpretation, and technology development is providing more options for remote interpretation. In-person interpretation is still the preferred method, but remote-interpretation remains an option when providers are working with patients who speak a "rare language." (MDH, 2015).

Most of the interpreters who work in health care settings are not employed by the hospital or health care system. The majority of health care interpreters in Minnesota work as independent contractors; the interpreters receive work referrals through multiple agencies. Some interpreting agencies and health care system have their own requirements and guidelines. However, these requirements vary significantly and there are no universal standards for interpreters to practice in Minnesota. As a result, the quality of language interpretation varies greatly (MDH, 2015).

The Challenges with Language Interpretation Faced by Other Professions

The importance of having a professionally trained language interpreter is crucial for the LEP patients. Studies have found that having well trained spoken language interpreters can improve the quality of care for LEP clients. Ngo-Metzger et al. (2007), reported with a well-trained interpreter, the LEP patients could receive clinical care almost equal to the care given to native English speakers. The LEP patients reported that having a trained interpreter helped them have a better understanding of their diagnosis and treatment; have greater satisfaction with their care; receive more appropriate care; and reduced overall medical costs (MDH, 2015). The benefits of having trained interpreters are well documented, but the lack of state level policies regarding interpreter practice in Minnesota creates challenges and barriers for all providers working with LEP patients.

Numerous studies have found that the use of in-person interpreters is preferred by majority of medical providers. Studies find that in-person interpreters make patients feel more at ease and create a more personal atmosphere during the exchange. However, the providers also expressed frustration regarding the limited availability of in-person interpreters (Michalec et al., 2015). Providers often report frustration of waiting for interpreters, or insufficient time for having the interpreter in the session (Hsieh, 2014). Medical providers often have to utilize remote interpretation due to time constraints and the availability of in-person interpreters (Locatis et. al., 2010). Video conferencing is the more preferred method of remote interpretation compared to phone interpretation; providers reported the visual communication was helpful but there are also downfall for the video interpretation. Providers often lose eye contact with patients (patients tended to watch the monitor), and there can be issues with set up time and technical problems (Locatis et al., 2010). Providers reported that phone interpretation imposed significant disruption to the providers' tasks: poor sound quality, awkward conversational style (e.g.,

passing the handset back and forth), and lack of interpersonal closeness created difficulties in establishing rapport (Hsieh, 2014). The biggest challenges for providers using remote interpretation is building rapport with patients and supporting the patients' emotional needs.

Even though interpreters need to be provided to LEP patients, many of them choose to utilize their family members or friends as their interpreter. Many studies found that due to the limited availability of in-person interpreters, medical providers would often use a patient's family members to assist in interpretation (Michalec et al., 2015; Hsieh, 2014; Ngo-Metzger et al., 2007). Studies found that family members as interpreters are helpful in assisting the patients' emotional needs. Patients who often come with trusted family members and friends are more willing to discuss deeper emotional feelings (Hsieh, 2014). However, family members are not considered ideal interpreters since they also pose a risk to patient autonomy. Studies found that in certain cultures, the male relatives would dominate discussions and create challenges for medical providers. The male relatives would speak for the female patients, have difficulty keeping patient privacy, or only want female interpreters to work with the patients, creating even more barriers for the patient to assess quality care (Michalec et al., 2015; Hsieh, 2014). Medical providers need to be culturally sensitive, but also navigate around cultural barriers to provider quality care for their patients.

In-person interpreters are viewed as the best way to assist LEP patients in medical settings. However, there are also many challenges that providers face when working with in-person interpreters. Many studies have found that medical providers have more challenges when working with interpreters who are not hired by their medical setting. Many medical settings contract out for interpreter services, or have to utilize an outside interpreter when the on-site interpreters are not available or the patient speaks a language other than those spoken by on-site

interpreters. Medical providers reported these contracted interpreters often lack medical knowledge, or they do not understand the procedure in the specific medical settings (Jackson et al., 2010; Ngo-Metzger et al., 2007; Kale & Syed, 2010). In-person interpreters would sometimes get involved in the conversation between the medical provider and patients. A study found that interpreters would sometimes change the wording of the patient's comments or add their own input they considered to be helpful when translating for both the provider and patients (Jackson, Nguyen, Hu, Harris, Terasaki, 2010). The study found that sometime those changes made by the interpreter had positive effects, but that there were overwhelmingly more negative effects than positive effects when the interpreters changed some of the content (Jackson et al., 2010).

The Social Worker Ethic

The National Association of Social Worker's (NASW) Code of Ethics highlights the ethical principles that help guide social work practice. The principles of competence suggest that social workers practice within their areas of competence and develop and enhance their professional expertise (NASW, 2008). However, there are no courses or trainings provided for social workers to develop their skills of working with interpreters. In school, social workers learn skills to build rapport with clients, but when working through an interpreter, there are other skills that are needed in order for the social workers to build a strong relationship with clients. Social workers need to develop more skills in order to practice with competence when working through interpreters. Just as social workers should aspire to contribute to the knowledge base of the professions, this research is conducted in hope of gaining more understanding of the challenges social workers face when working with LEP clients through an interpreter. In gaining more understanding of the challenges, social workers can then challenge the social injustices that are

presented in these situations. The principle of social justice directs social workers to challenge social injustice, and to pursue social change, particularly on behalf of vulnerable and oppressed individuals and groups of people (NASW, 2008). Without the proper understanding of the challenges that social workers face while working through interpreters, social workers cannot help the LEP clients to pursue social change. The ethical principles guide us to gain more knowledge, and challenge this social injustice.

Social workers could possibly face similar challenges as medical providers when working with LEP patients at a medical setting. The social workers often have to focus on more sensitive topics with patients, making it important for the interpreters to assist both the social worker and the patient throughout the exchange. This research study aims to gain more understanding of the challenges that medical social workers might face when working with LEP patients through an interpreter. With an understanding of the challenges, social workers can learn the necessary skills for working with interpreters and advocating for LEP patients to help them receive better care.

Conceptual Framework

The critical race theory was used to help guide this research study. The critical theory focuses on the power dynamic between the dominant and subdominant groups in society. In critical race theory, race is the primary determinant of dominant and subdominant groups. Solorzano, Ceja, and Yosso (2000) defined race as “a socially constructed category, created to differentiate racial groups and show that superiority or dominance of one race (typically, Whites in the U.S.) over others.” The essential construct of critical race theory is that minority groups are subordinate to the majority group in terms of power and privilege (Trahan & Lemberger, 2013). Very rarely is the majority group (Whites) deliberately prejudiced toward the minority group; however racial inequities are so deeply ingrained in American society that they are nearly invisible, and most White Americans are unaware of the advantages they enjoy in society and of

how their attitudes and actions unintentionally discriminate against minority groups (Advisory Board to the President's Initiative on Race, 1998). The critical race theory gives us a lens to help to understand the current healthcare disparity between American majority and minority groups. The theory asserts that despite the progress that has been made in United State to alleviate racism, it is still present and ingrained in contemporary society.

The empowerment theory is used to help analyze the use of interpreters to help empower the LEP patient when communicating with medical social workers. The empowerment theory focuses on the process by which an individual or group gains power to access resources and to control the circumstances of their lives. At the core of empowerment theory are the concepts of power and powerlessness. One's "ability to access and control resources and people" represents power in the context of empowerment theory (Robbins, Chatterjee, & Canda 2012).

Practitioners of the theory of empowerment focus on helping individuals develop skills for successfully navigating structural barriers, while also developing "critical consciousness." Robbins, et al. (2012) describes this consciousness raising as "the process of increasing awareness of how political structures, personal assumptions, and unequal distribution of power affect individual and group experience and contribute to personal or group powerlessness." This theory focuses on the structural barriers that prevent people from accessing resources for their well-being. Guided by empowerment theory, the social worker also assists individuals in identifying the sources of powerlessness and helps them to redefine themselves in a more positive, self-determined manner, using the strength perspective (Greene, Lee, & Hoffpauir, 2005). Empowerment theory provides a lens to understand the use of an interpreter and how it affects families and services providers. I Interpreters are provided to give more power to the LEP patients so they can be on more equal ground with the service providers. However, due to the

lack of training for social workers and interpreters, the interpreter services could often create more difficulty for the patients.

Using the lens of critical race theory, dominant groups (Whites) have privilege over minority groups (LEP patients/ non-white) in the healthcare system. With the majority of healthcare providers and social workers being Caucasians who speak English, the minority groups, LEP patients (many non-Caucasians) are given less power in the healthcare system. The disempowerment of LEP patients can also be observed in the barriers to quality care in the healthcare system. This disempowerment is demonstrated by the communication barriers created by the dominant groups and lack of effort in providing quality assistance to minority groups when they are facing challenges. The interpreters serve as a tool to give more power to the minority group, but with the lack of state level policies to regulate language interpretation qualification and training, it often creates more challenges and difficulties for both the providers and patients, resulting in micro-aggressions toward LEP patients.

Method

The purpose of this study was to explore the use of interpretation in a medical setting; the study focused on the social worker's experiences and perspectives. This study used an electronic mixed-method survey, hosted on the website Qualtrics, to examine respondents' experiences and perspectives regarding this topic. The sample for this study included social workers who work in a medical setting. These respondents were found through purpose sampling and then a snowball sampling. After the data was collected, it was analyzed in order to examine the following research questions:

1. What was the amount of spoken language interpretation usage in a medical setting; what mode of interpretation was utilized the most?

2. How did each mode of interpretation perform compared to each other?
3. Is there a relationship between the amount of interpretation usage and the performance rating of each spoken language interpretation?
4. What potential challenges and/or benefits of spoken language interpretation use exist that have not been previously discovered?

Research Design

The research design for this study was a mixed-methods survey; utilizing both quantitative and qualitative questions. The survey was written with both closed and open ended questions to examine the research questions. The survey was divided into four sections to examine the following: demographics, interpretation culture at their medical agency, satisfaction with interpretation, and the qualitative answers of the respondents. The first three sections of the survey examined specific aspects of the use of interpretation at the respondents' work setting. These section examined the amount of interpretations usage, what type of interpretations were used, and the satisfaction of the respondents. These sections were quantitative. The final section was qualitative. This section of the survey examined different benefit and challenges that social workers might have experiences as well as other ethical dilemmas and suggestions from the social workers. Qualtrics, an online survey tool, was used to distribute the survey and collect answers.

Sample

The population for this study were medical social workers working within the Twin Cities metropolitan area. Once the study was approved by the St. Catherine University Internal Review Board (IRB), emails were sent out to MSW students working in a medical setting, and social workers working in the medical setting. The MSW students only assisted in distributing the survey e-mail to their colleagues who are social workers. Purposeful sampling was utilized in

this study, with the email sent to pre-selected social workers, Snowball sampling was also utilized to increase the numbers participants in this research study. This study included all medical social workers who have been working at a medical setting for at least one year. The research excluded social workers who have worked less than one year in a medical setting. A total of 46 completed surveys met the study criteria.

Protection of Human Subject

This study was reviewed and approved by both a research committee and the Institutional Review Board (IRB) at the St. Catharine University in St. Paul, Minnesota to ensure that human subjects would be protected. The intended respondent sample coupled with the research topic did not infer any issues regarding vulnerability. There were no known risks for harm or discomfort for respondents in this study. The questions that were asked of respondents were not known to cause any potential harm, as they were related to the professional responsibilities of the worker. Although respondents did add to the current knowledge base surrounding the intersection of social work and interpretation, there were no direct benefits to participation in this study. The initial e-mail that was sent to respondents included a link to complete the survey on Qualtrics and a request to forward the e-mail to other social workers at a medical setting.

Prior to beginning the survey, the participants were provided with an informed consent form (Appendix A) approved by the St. Catherine University's IRB. The consent form described the relevance of the survey and explains that it is voluntary in nature with no known risks or benefits for participation in the research. The respondents remain anonymous as the survey was distributed through the internet using the Qualtrics survey system. Participants were informed that the survey is being completed for a Master of Social Work research project and an analysis of the data is going to be utilize in a public presentation. The contact information of the researcher and their designated chair were provided in the consent form should participants have

additional questions. The data that was collected through Qualtrics was kept on the principle investigator's password-protected personal computer. At completion of this research project, in June of 2016, all tangible material is going to be shredded and electronic correspondence is going to be permanently deleted.

Data Collection

The instrument used for this study was a mixed-methods survey that was created by the researcher (Appendix B). The survey consisted of both close-ended and open-ended questions. The survey was divided into four sections. The first sections of the survey included demographic questions. The second section of the survey consisted of questions around the interpretation cultures at the respondents' medical agency and the amount of usage for different types of spoken language interpretation. The third section of the survey was the satisfaction of working with interpretation for the respondents. The scale questions for this section was adapted from previous research done by Locatis et. al. (2010) regarding medical provider's perspective and satisfaction when working with interpreters through different methods. It is noted that the scales in the survey were created by the researcher to reflect the data found in the literature review and the conceptual framework. In the last section of the survey, respondents were asked to reflect on their experience as a medical social worker working with interpreters open ended questions. These open-ended qualitative questions allowed the respondents' experiences of working with interpretation to be examined more broadly. These measures contained face validity after being reviewed by the research chair and committee members for this study (Monette et al., 2011). Not all questions are asked to all participants as some questions are only asked based on a particular answer to a previous question. The follow up questions were designed to gain more information about a particular response. The data was gathered with Qualtrics, an online survey platform provided and approved by the University of St. Thomas.

Data Analysis Plan

All quantitative data gathered by this study were analyzed using analysis tool SPSS. Data collected from open-ended (qualitative) survey questions are going to be analyzed using content analysis techniques (Padgett, 1998). The data collected by the open-ended questions were analyzed for themes. The themes identified are going to be compare with previous research data that was identified in the literature review around challenges and benefits of working with spoken language interpreters.

Descriptive statistical analysis

“Descriptive statistical analysis assists in organizing, summarizing, and interpreting data” (Monette, Sllivan, Dejong, & Hilton, 2014). Descriptive statistics were utilized to examine most of the survey data. Frequency distributions texts were done to examine demographic categories such as: gender, licensure, and ethnicity of the social workers. Central tendency tests were done to analyze the variables such as: years in practice, length of time employed as a medical social worker, uses of interpreters, modes of interpretation, and the satisfaction with interpretations.

Inferential statistical analysis

“Inferential statistics encompass a variety of statistical significance tests that investigators can use to make inferences about their sample data” (Allua & Thompson, 2009). Inferential statistics evaluate differences, examine relationships, and make predictions. For this study, logistic regression tests were done to help answer the research question. The logistic regression tests were completed in SPSS to statistically analyze the following research question: Is there a relationship between the level of satisfaction and the amount of a certain interpretation usage?

Qualitative data analysis

The qualitative data were gathered from the open-ended narrative questions. These questions allowed the social workers to elaborate on their individual experiences on working

with interpreters. A qualitative analysis was used to analyze the open ended qualitative questions. Data collected from open-ended survey questions is going to be analyzed using content analysis techniques (Padgett, 1998). The qualitative data is going to be analyzed through the process of coding. Themes were then be developed based off of similarities among the codes (Monette, Sllivan, Dejong, & Hilton, 2014). Common themes were pulled from the qualitative responses and were analyzed using thematic analysis. The themes will then be compare to the themes found by previous research studies. The quotations included in the qualitative analysis were edited for spelling and basic grammar mistakes before analysis. No editing was done that changed the meaning of the responses.

Results

This purpose of this research study was to examine the experiences of medical social workers regarding working with LEP patients through a spoken language interpreter. The study examined the amount of interpretation used in this work setting and how each type of spoken language interpretation impacted the work between social workers and clients. The study was primarily exploratory. As stated previously, the research questions guiding this study emerged as a result of gaps in previous literature. The first research questions explored the amount of spoken language interpretation usage in a medical setting and what mode of interpretation was utilized the most. The second research question examined how each mode of interpretation performance compared to each other. The performance rating was based on the social worker's perspective. The third research question examined the potential relationship between the amount of interpretation usage and the performance rating of each spoken language interpretation. Finally, the last research question explored the potential challenges and/or benefits of spoken language interpretations use that have not been previously discovered.

In total, there were 58 surveys that were started. Twelve respondents did not complete the survey. These responses were not included in the analysis, which means that the total number of respondents was 46. The findings show that all social workers who completed the survey utilized spoken language interpretation during their practice, and 60% of them utilized interpretation more than 2-3 times a month. Most of the spoken language interpreters utilized were medical interpreters and the most common mode of interpretation was in-person interpretation. In terms of the social worker's perception of each mode of interpretation, the in-person interpretation was rated the highest among respondents. In relation to the final research question, the findings of this study support the previous literature. No themes emerged within the qualitative data that have not been discussed in some capacity in the previous literature.

Table 1

<i>Demographic Characteristic</i>	<i>n</i>	<i>%</i>
Gender		
Male	2	4.3
Female	44	95.7
Age		
20-29	11	23.9
30-39	22	47.8
40-49	4	8.7
50+	9	19.6
Ethnicity		
Asian	2	4.3
Caucasian/White	44	95.7
Licensure		
LGSW	14	30.4
LISW	2	4.3
LICSW	30	65.2
Medical Setting Experiences		
1-5 Years	20	43.5
6-10 Years	17	37.0
11-15 Years	2	4.3
16-20 Years	1	2.2
20+ Years	6	13.0

Demographics

Gender. The first demographic variable that was measured was the respondent's gender. A descriptive statistical analysis was run to analyze the variable. Of the 46 respondents who answered this survey question, two respondents (4.3%) were male and forty-four respondents (95.7%) were female.

Age. The second demographic variable that was measured was respondent age. Measures of central tendency were computed to summarize the data for this variable. Measures of dispersion were also computed to understand the variability of scores for this variable. Of the 46 respondents that answered this survey question, the average age was 36.19 years ($SD = 9.63$). The minimum age was 24 years and the maximum age was 58 years.

Ethnicity. The third demographic variable explore the respondent's ethnicity. The respondents were asked about what ethnicity they identified with. A descriptive statistical analysis was ran to analysis the variable. Of the 46 respondents that answered this survey question, two respondents (4.3%) reported to identify as Asian and forty-four respondents (95.7%) reported to identify as Caucasian/White.

Professional licensure. The fourth demographic variable that was measured was the level of professional licensure of the respondents. The response options were: LSW, LGSW, LCSW, and LICSW. The findings of this study show that 14 respondents (30.4%) reported to be license as LGSW, 2 respondents (4.3%) reported to be license as LCSW, 30 respondents (65.2%) reported to be license as LICSW, and 0 respondents reported to be license as LSW. These findings, as seen in Table 1, show that a majority of respondents are licensed as LICSW.

Professional Medical Experiences. The final demographic variable that was measured was professional experience of working in a medical setting. This variable explored how long

respondents have worked within the medical setting. The respondent was able to fill in their response in a text box. As seen in Table 1, the findings of this study show that 20 respondents (43.5%) reported 0-5 years of experience, 17 respondents (37.0%) reported 6-10 years of experience, 2 respondents (4.3%) reported 11-15 years of experience, 1 respondents (2.2%) reported 16-20 years of experience, and 6 respondents (13.0%) reported 20+ years of experience.

Quantitative Findings: Agency Culture around Interpretation

Training in regarding to working with interpretation. The first variable explored was whether the social worker received any training regarding working with interpreters at their current work setting. A descriptive statistical analysis was ran to analyze the variable. Of the 46 respondents that answered this survey question, 22 respondents (47.8%) reported “yes” that they did receive training and 24 respondents (52.2%) reported “no” that they did not receive training in regard to working with interpretation.

Table 2

<i>Interpretation Culture</i>	<i>n</i>	<i>%</i>
Receive training to work with Interpreters		
Yes	22	47.8
No	24	52.2
Frequency of interpretation use		
Less than once a month	10	21.7
Once a month	8	17.4
2-3 times a month	13	28.3
Once a week	5	10.9
2-3 time a week	8	17.4
Daily	2	4.3
Use of Medical Interpreters		
Never/Rarely	2	4.4
Sometimes	4	8.7
Often/All the time	40	86.9
Outside Agency		
Never/Rarely	16	34.8
Sometime	18	39.1
Often/All the time	11	23.9

Frequency of Interpretation Use. The frequency of spoken language used with patients was examined in this survey. Respondents were asked how frequently they utilized interpretation during their practice. The response options for each question were: Less than once a month, once a month, 2-3 time a month, once a week, 2-3 time a week, and daily. All respondents who completed the survey reported using spoken language interpretation during their practice. The findings, as seen in Table 2, show that only 18 respondents (39.1%) reported that they use interpretation less than once a month/once a month. 13 respondents (28.3%) reported that they use interpretation 2-3 times a month. 15 respondents (32.6%) reported that they use interpretation more than once a week. These findings, as seen in Table 1, show that a majority of respondents used interpretation more than 2-3 times a month.

Types of Interpretation Use. The frequency of spoken language use with patients was examined in this survey. Respondents were asked how frequently they use each type of interpretation with their patient: medical interpreter or interpreter from an outside agency. The response options for each question were: never, rarely, sometimes, often, and all the time. The total number of respondents for the variable in relation to medical interpreter use was 46, compared to 45 respondents for outside agency interpreter. The findings, as seen in Table 2, show that only 2 respondents (4.4%) reported that they never/rarely use medical interpreter, compared with 16 respondents (34.8%) who reported that they never/rarely use interpreters from outside agency. 4 respondents (8.4%) reported that they sometimes use medical interpreters and 18 respondents (39.1%) reported that they sometimes use interpreters from an outside agency. 40 respondents (86.9%) reported that they often/all the time use medical interpreters, compare to only 11 respondents (23.9%) who reported that they often/all the time use interpreters from an outside agency.

Table 3

<i>Interpretation Usage</i>				
	Never <i>n</i> (%)	Rarely/ Sometimes <i>n</i> (%)	Often/ All the Time <i>n</i> (%)	Mean
Modes of Interpretation				
In-person Interpretation	0	6 (13.0)	40 (87.0)	4.11
Telephone Interpretation	3 (6.5)	22 (47.8)	21 (45.7)	3.26
Video Interpretation	20 (43.5)	20 (43.5)	6 (13.0)	2.02
Bilingual Staff on site	14 (30.4)	20 (43.5)	12 (26.1)	2.50
Patient's family members or friends	13 (28.2)	27 (58.7)	6 (13.0)	2.20

Quantitative Findings: Mode of Interpretation Usage

Mode of Interpretation Use. Respondents were asked how frequently they used each mode of interpretation (in-person, phone, video, hospital staff, and patient's family member/friends). The response options for each question were: never, rarely, sometimes, often, and all the time. The findings, as seen in Table 3, show that the most common mode of interpretation usage was in-person interpretation with 40 respondents (87.0%) reporting that they often/all the time use in-person interpretation while 0 respondents reported to never use in-person interpretation. The least common mode of interpretation usage was video and patient's family members/friends. Both modes of interpretation had 6 respondents (13.0%) who reported that they often/all the time used these mode of interpretation. Also, 20 respondents (43.5%) reported that they never use video interpretation, which is the most "never" usage out of the all five options. Telephone interpretation was the second most reported usage out of the five options, with 21 respondents (45.7%) reporting that they often/all the time use these modes of interpretation and only 3 respondents (6.5%) reporting that they never use telephone interpretation. Bilingual staff on site was in the middle with 12 respondents (26.1%) who reported that they often/all the time

used these mode of interpretation and 14 respondents (30.4%) who reported that they never use bilingual staff on site for interpretation.

Quantitative Findings: Social Worker's Perceptions Regarding Each Type of Spoken Language Interpretation

Overall Rating of Each Mode of Interpretation. Respondents were asked to rate how they felt the interpreters were doing in each mode of interpretation: in-person, phone, video, bilingual staff, and patient's family member/friends interpretation. The ratings were based on the social worker's perception of the interpretation's ability to notice the dynamics in the room, respect client's privacy, and stay neutral during meetings. There were a total of eight questions and the questions are presented in Table 5. The rating questions were only asked to the respondents who previously answered that they used those mode of interpretation. The ratings were based on a five point Likert-scale from (1) Strongly disagree to (5) Strongly Agree. The mean/standard deviation of each questions for each mode of interpretation are presented in Table 5. The overall rating of each mode of interpretation was based on the sum of the eight scale questions. The maximum rating is 40, and minimum is 8. As seen in Table 4, the *n* number for each mode of interpretation is different, since not every respondent reported using every mode of interpretation.

The mode of interpretation with the highest rating was in-person interpretation. 46 respondents (100%) reported that they utilize in-person interpretation and the overall rating for it was 30.93 out of maximum rating of 40. Bilingual staff interpretation was rated at second with 32 (69.6%) respondents reporting that they use bilingual staff interpretation, and the overall rating for it was 30.33. Patient's family members/ friends interpretation was rated last with 33 respondents (71.7%) who reported that they use patient's family members/ friends'

interpretation, and the overall rating for it was 25.31. Telephone and video interpretation were in the middle with ratings of 26.70 and 27.59 respectively. The in-person interpretation has the highest overall rating of 30.93, while patient's family member/ friend's interpretation has the lowest overall rating of 25.31.

Table 4

<i>Interpretation Satisfaction</i>				
	<i>n</i>	Mean	Minimum	Maximum
Types of Spoken Language Interpretation				
In Person	46	30.93	21	40
Phone	43	26.70	12	40
Video	26	27.59	21	35
Bilingual Staff on Site	32	30.33	22	40
Patient's family member/ friends	33	25.31	17	33

Client Privacy and Interpretation Bias. One of the questions asked the respondents to rate how well they felt the client's privacy was respected. The mode of interpretation that respondents felt the client's privacy was most respected with in-person interpretation with the average rating of 4.04 out of 5. The mode of interpretation that respondents felt least respected the the client's privacy was the patient's family members/friends interpretation with the average rating of 3.06 out of 5.

Another question asked about interpretation bias during the meeting. The respondents were asked to rate how well they felt the interpreter remained neutral during the meeting. The highest rated modes of interpretation were phone and video interpretation, with the rating of 3.55 and 3.52 respectively. The lowest rating was patient's family members/ friends, with a rating of 2.28 out of 5. The two highest rated mode of interpretation was where the interpreters were not in the same room as the respondents and patient.

Table 5

<i>Interpretation Rating for Mode of Interpretation</i>					
	In-person Mean/SD	Phone Mean/SD	Video Mean/SD	Staff Mean/SD	Family Mean/SD
Questions					
I felt the client was at ease during the meeting	4.00/0.56	3.10/0.92	3.16/0.69	3.94/0.63	3.81/0.82
I felt the client was heard and understood me	3.89/0.74	3.28/0.93	3.44/0.58	4.00/0.59	3.28/0.85
I felt the client's privacy was respected	4.04/0.42	3.60/0.78	3.64/0.76	3.71/0.74	3.06/0.91
I felt the interpreter noticed when I/ the client had problems understanding	3.80/0.83	2.73/0.93	3.24/0.60	4.00/0.58	2.97/0.97
I felt I had opportunities to ask questions	4.04/0.59	3.75/0.67	3.72/0.61	3.77/0.76	3.41/0.91
I felt the client had opportunities to ask questions	4.11/0.43	3.70/0.76	3.67/0.56	3.90/0.75	3.66/0.72
I felt the interpreter was neutral during the meeting	3.41/0.88	3.55/0.71	3.52/0.51	3.45/0.85	2.28/0.92
I felt comfortable when working with clients through interpretation	3.64/0.98	2.98/0.97	3.25/0.90	3.55/0.93	2.84/0.95

Respondent and Client Comfort. The respondents were asked to rate how comfortable they felt about working with interpretation and also rate how they perceived the client's comfort level with interpretation. The respondents rated in-person interpretation highest in both the respondent's and patient's comfort level working with interpretation, with the rating of 3.64 and 4.00 respectively. The respondents rated patient's family members/ friends as the mode of interpretation they felt least comfortable working with, with a rating of 2.48 out of 5. The respondents rated phone interpretation as the mode they felt the client was least comfortable with when working in the meeting with the rating of 3.10 out of 5.

Use of Remote Interpretation. The usage of remote interpretation was examined in the study: phone and video interpretation. The usage of remote interpretation created a different

dynamic in the room compared to when the interpreter was in the room with the social workers and patients. The respondents felt the client was least comfortable when utilizing phone and video interpretation; the rating of phone and video interpretation was the lowest with the rating of 3.64 and 4.00 respectively. The respondent rated phone interpretation lowest in area that requires a visual such as: able to notice when the clients or social workers had problems with understanding. However, the respondents rated remote interpretation highest in the area of which they felt the interpreter was neutral during the meeting.

Table 6

<i>Ease of Use</i>	<i>n</i>	Mean	Minimum	Maximum
Types of Spoken Language Interpretation				
In Person	46	7.11	2	10
Phone	43	7.15	2	10
Video	26	7.00	6	10
Bilingual Staff on Site	32	7.03	4	10
Patient's family members/ friends	33	6.44	4	10

Accessibility for each mode of Interpretation. Respondents were asked to rate how they felt about the accessibility of each mode of interpretation: in-person, phone, video, bilingual staff, and patient's family member/friends interpretation. The rating questions were only asked to the respondents who previously answered that they used those mode of interpretation. The respondents were asked to rate two questions: It was easy to make an appointment, and I had sufficient time working with the interpreter. The ratings were based on a five point Likert-scale from (1) Strongly Disagree to (5) Strongly Agree. The mean/standard deviation of each questions for each mode of interpretation are presented in Table 7. The overall rating of each mode of interpretation was based on the sum of the two scale questions presented in Table 7. The maximum rating is 10, and minimum is 5. As seen in Table 6, the *n* number for each mode of

interpretation was different, since not every respondent reported using every mode of interpretation.

The mode of interpretation with the highest rating was phone interpretation. 43 respondents (93.5%) reported that they utilized phone interpretation, with a rating of 7.15 out of 10 for the accessibility of the service. In-person interpretation was rated at second with 46 (100%) respondents reported that they utilized in-person interpretation and the overall rating for it was 7.11. Patient's family members/ friends interpretation was rated last with the overall rating for it was 6.44. Video and bilingual staff interpretation were in the middle, with ratings of 7.00 and 7.03 respectively. The phone interpretation had the highest overall rating of 7.15, while patient's family member/ friend's interpretation had the lowest overall rating of 6.44.

Table 7

<i>Accessibility Rating for Each Mode of Interpretation</i>					
	In-person Mean/SD	Phone Mean/SD	Video Mean/SD	Staff Mean/SD	Family Mean/SD
Questions					
It was easy to make an appointment	3.63/0.93	3.58/1.01	3.24/0.83	3.74/0.89	3.16/0.85
I had sufficient time working with the interpreter	3.48/1.09	3.85/0.74	3.71/0.62	3.29/0.82	3.28/0.77

Inferential Statistic Finding: Relationship between Performance Rating and Amount of Use

An Inferential Statistical test was run to test the relationship between performance rating and the amount of usage for each mode of interpretation. The logistical regression test was run for each mode of interpretation. The performance rating was the independent variable and the average of usage was the dependent variable. The findings showed there was e no significant relationship between performance rating and the amount of usage.

Table 8

<i>Qualitative Questions</i>	
	<i>n</i>
Questions	
What benefits do interpreters bring to your work other than interpreting the languages?	43
Does interpretation create challenges to your work? In what way?	43
Are there any situations that you would or would not talk to a patient without an interpreter?	42
Are there any situations that you would or would not talk to a patient without an interpreter?	38

Qualitative Findings: Spoken Language Interpretation

The survey for this study included four qualitative questions. The four questions are presented in table 8. As presented in Table 8, not every respondent filled out an answer for every qualitative questions. The analysis was done for all the responses that were received. These questions were analyzed using content analysis. The themes that emerged from benefits of spoken language interpretation were cultural awareness and helping clients feel comfortable. Themes that emerged from challenges of interpretation were difficulty scheduling, lack of medical knowledge, uncertainty about the accuracy of interpretation, and difficulty in forming a therapeutic relationship. The quotations included in the qualitative analysis were edited for spelling and basic grammar mistakes before analysis. No editing was done that changed the meaning of the responses.

Benefits of Use. When asked to identify other benefits of using spoken language interpretation, many respondents reported that the interpreters hugely improve their work when working with LEP patients. One of the main themes was that interpreters help bridge the gap between cultures. As one respondent stated, “Interpreters can help to educate about cultural nuances that may be impacting the patient.” Numerous respondents alluded to how an

interpreter's knowledge about a patient's culture helps the social workers in understanding the patients in more detail. Another respondent described: "They can help with cultural competency education and provide contextual information." Another respondent reported "They sometimes offer ideas or resources that are culturally appropriate that I was not aware of." Apart from the cultural awareness, some of the other benefits of interpretation included the following: increased comfort for the patients and improved client self-determination. As one respondent stated, "Patients seem to find it comforting as interpreters may better understand their culture." Another respondent reported, "They put the unit at ease because the families are being heard and educated" in regard to a client's self-determination. For example, one respondent stated, "It allows for patient self-determination and understanding. Gives them a voice."

Challenges of Use. The second question explored the possible challenges the social worker might face when working with spoken language interpretation. Within this question, four themes emerged. These themes include difficulty scheduling/ not enough time, lack of medical knowledge, unsure about the accuracy of interpretation, and difficulty in building therapeutic relationship.

Difficulty scheduling/ not enough time. There were many responses that reported challenges in scheduling interpreters or not having enough time working with interpreter. As one respondent reported, "...It takes much planning to schedule and be available during the same time." Another respondent reported something similar: "Not always being available. Rarely have interpreters 24/7 during a patient's time in the hospital." Due to the availability of the interpreters, social workers often faced challenges of not having enough time to work with patients. As one respondent stated, "Often they are scheduled for only a certain amount of time which is a problem when doctors are late." Another respondent reported that, "Occasionally late

for appointments or not able to stay longer.” A third respondent stated, “It's difficult when we only have an interpreter for part of our shift or workday.”

Lack of medical knowledge. Many respondents reported challenges related to the interpreter's lack of medical knowledge. For one respondent, the issue of the lack of medical knowledge was the main challenge when working with interpreters. As this respondent reported: “The interpreters present ...only when they cannot understand the clinical medical information.” Another respondents reported that, “Sometimes the medical information is difficult to explain to them to interpret correctly.” Other respondents alluded to the fact that medical interpreters are not always available due to their schedule or the language need for the client, thus resulting in them using interpreters from outside agencies. A respondent stated, “Not all have medical background or if it is a phone interpreter, they may not understand local programs.” Another respondent reported, “Outside agencies are more difficult to work with as they are visibly not engaged in the meetings/appointments with our patients/families. They are not always neutral and not always interpreting everything we ask them to. Staff Interpreters (on hospital site) are much more engaged though difficult to schedule d/t shortage of specific language interpreters.”

Unsure about the accuracy of interpretation. Some respondents reported challenges related to the fact that they are unsure about the accuracy of the interpretation. One respondent stated, “I don't know whether something is being interpreted accurately and may seem that it is not enough...” Many of the respondent reported that they feel the conversation is disjointed and they cannot be sure that the interpreters are interpreting everything. One respondent sated, “many interpreters do not translate directly and instead paraphrase. They appear biased at times.” Another respondent reported something similar, “I have had interpreters insert themselves into the interview--- not just interpret.” A third respondent stated, “Sometimes I wonder if they are

interpreting things correctly since the patients' answers don't always make sense given the question I ask.”

Difficulty in building therapeutic relationship. The last theme emerged was the challenge of building a relationship between social workers and patients. Numerous respondents reported feeling disengaged from a client since they are communicating through another person. One respondent stated, “Hard to assess non-verbal and verbal communication when it's going thru someone else.” Another respondent stated, “It's difficult to express empathy through the interpreter.”

Situation to not use interpretation. 20 respondents (47.6%) reported that they will always use interpretation when working interacting with client. 7 respondent (7%) reported that they would interact with client without interpretation only when it is a short basic greeting. One respondent stated, “To say hello if I knew they understood that basic greeting.” Another respondent stated, “I typically use interpreters for all encounters with a patient, unless it is for something very simple & small and I can use my Spanish skills (if it's a Spanish speaking patient!).” A few other situations listed were medical emergency when there are no interpretation available, delicate situation such as domestic violence, when patients know the interpreter is in their community and privacy won't be maintained, and when patients decline to use interpretation.

Discussion

The study examined the experiences of medical social workers regarding working with LEP patients through a spoken language interpreter. The findings show that all social workers who completed the survey utilized spoken language interpretation during their practice, and 60% of them utilized interpretation more than 2-3 times a month. Most of the spoken language

interpreters utilized were medical interpreters and the most common mode of interpretation was in-person interpretation. In terms of the social worker's perception of each mode of interpretation, the in-person interpretation was rated the highest among respondents. In relation to the final research question, the findings of this study support the previous literature. No themes emerged within the qualitative data that have not been discussed in some capacity in the previous literature. However, the qualitative data from this study is important since it focuses on the perception of social workers, which has not been studied much in the past.

Interpretation Culture in Medical Settings

The study focused on the experiences of social workers practicing at a medical setting in the Twin Cities metropolitan area. The majority of the social workers (over 60%) reported using some sort of interpretation at least 2-3 times a month. Several respondents reported using interpretation weekly or even daily. With the high usage of interpretation when working with patients, surprisingly, less than half of the respondents reported receiving any training in regards to working with interpretation from their work setting. When asked about the amount of usage between medical and outside agency interpreters when working with LEP patients; Over 80% of respondent reported they utilize medical interpreter often or all the time when working with LEP patient. It was assumed by the researcher when using the term medical interpreters, it would allude to interpreters that are employed by the medical facilities. However, the respondents could have interpreted the term medical interpreters differently as to any interpreters that are trained in and specializes in medical terminology who might not be employed by the medical facilities. Interpreters from an outside agency were most often called in with the LEP patient spoke a less common language different from any spoken by on-site medical interpreters, and when the onsite medial interpreters were unavailable.

Out of all the different modes of interpretation, in-person interpretation was also utilized the most out of all the modes of interpretation, which is consistent with previous studies (Jackson et al., 2010; Ngo-Metzger et al., 2007; Kale & Syed, 2010). The use of in-person interpretation was also rated the highest out of all the different modes of interpretation. The respondents reported they felt it was easiest for the social workers and patients to communicate back and forth. They felt it was easiest for them or the patients to ask questions and the interpreters were able to pick up different non-verbal cues that remote interpretation lacks. The usage of family members/ friends as interpreters was also examined in this study. 30% respondents reported that they never use patient's family members/ friends. However, over a quarter of respondents reported that would use patient's family members/ friends often or all the time when working with LEP patients. Even though this finding is consistent with previous findings, it was one of the least utilized modes of interpretation other than video interpretation. The use of family members/ friends interpretation was rated the lowest by the respondents. The respondents reported that it does not always respect the patient's privacy and that the interpreters are not always neutral during the meeting.

The usage of remote interpretation was also examined in the study. There haven't been many studies done on the usage of remote interpretation in the past. From our findings, the use of phone interpretation is rather prevalent. Almost half of the respondent reported they utilized phone interpretation often/ all the time. On the other hand, the use of video interpretation is still low. The majority of the respondents reported never using or rarely using video interpretation. From some of the responses, technology could be a challenge when using remote interpretation. Respondents reported difficulty understanding over the phone/video, clients felt uncomfortable, and the interpreters were not able to pick up non-verbal cues. Interestingly, the respondents also

reported they felt the patient's privacy is well respected and the interpreters are the most neutral during meeting out of all the different modes of interpretation.

The Effectiveness of Interpretation.

Spoken language interpretation brings many extra benefits other than just interpreting the language. Almost all respondents reported that language interpreters are helpful in many situations. The interpreters make it possible for the social workers and patients to communicate. The interpreters also bring in their knowledge about the patient's culture. The social workers are able to work with patients more smoothly because of the extra cultural awareness. The interpreters can help explain the different culture nuances to the social workers to improve communication. The importance of understanding the patient's culture was also presented in previous studies, where they found that bilingual social workers reported it is easier to build relationships and for their clients to trust them since they speak their language and understand the culture (Engstrom & Min, 2004). The understanding of culture helps ground and guide the interaction between social workers and patients.

Medical interpreters are favored over outside agency interpreters. The medical interpreters were assumed to be interpreters employed by the medical facilities. From the responses, the respondents identified positive qualities such as knowledge of medical terms and conditions. Medical interpreters also have knowledge of their hospital system (which they are employed at) and they are knowledgeable of local resources that could be available to the patients and their families. From that result, it could be assumed that many respondents also inferred the term medical interpreters as interpreters employed by their work setting. However, if a patient speaks a language that is less common, the social worker will need to use outside

agency interpreters. The interpreters might not have any knowledge about medical terms thus making it difficult to explain complex situations with patients.

Challenges of Interpretation

Many of the challenges named by the social workers in this study are consistent with challenges found in previous studies. Previous studies were mostly focused on other healthcare providers and this study focused on social workers in a medical setting. The limited availability of interpretation is identified as the biggest challenge. The interpreters are not available 24/7 and scheduling for interpreters also presents a big challenge. Respondents reported that there is often not enough time to communicate with patients or that they had to wait to communicate with patients due to the limited availability of interpreters. This is consistent with the previous finding from other providers that reported frustration of waiting for interpreters, or insufficient time for having the interpreter in the session (Michalec et al., 2015; Hsieh, 2014).

Even though in-person interpretation is viewed as the best way to assist patients, there are still challenges presented. In this study, some respondents reported the conversation often became disjointed or the interpreters injected themselves too much into the conversation. This is consistent with findings from previous studies where they found that interpreters would sometimes change the wording of the patients or add what they thought would be helpful when translating for both the provider and patients (Jackson et al., 2010). Another challenge with in-person interpretation is the lack of availability of medical interpreters. Medical interpreters are considered the most helpful from previous studies since they also have medical knowledge and often know how the medical system work. The findings from this study are consistent with previous studies that found that outside agency interpreters often lack medical knowledge, or

they do not understand the procedure in the specific medical settings (Jackson et al., 2010; Ngo-Metzger et al., 2007; Kale & Syed, 2010).

Interpretation using a patient's family members/friends is another challenge that is consistent with previous studies. If a patient declines the use of professional interpretation and decides to utilize their family members/ friends, the social worker has to respect their choice. However, the use of family members/ friends presents challenges since they are not knowledgeable of medical conditions or medical terms; it is also a risk to the patient's autonomy if the family interpreter injects themselves too much into the conversation. Nonetheless, the social workers limited their use of family interpretation compared to the previous studies. The previous studies found that the medical providers would often use patient's family members to assist in interpretation due to the limited availability of interpretation (Michalec et al., 2015; Hsieh, 2014; Ngo-Metzger et al., 2007). This study found that the social workers reported to only use family interpretation when the patients decline professional interpretation, exchanged short greetings, or in a medical emergency. The social workers reported to utilize professional interpretation as often as possible to provide quality and ethical services.

Implication for Social Work Practice

Since the huge wave of immigrants coming into the United States, the country has had to struggle to provide equal and quality services and treatment to populations with limited English ability. Many professions struggle to provide equal and quality services because of possible language and cultural barriers. As social workers, the profession needs to be aware of the social justice implications of language access for LEP clients in the US. In the social work ethic, the profession strives to treat all people as equal and be culturally competent when working with different populations. It is inevitable that social workers in a medical setting will need to provide

services to patients with limited English ability. Most social workers are required to utilize interpretation when working with LEP patients. These social workers face the challenge of culture competency, confidentiality, and patient's self-determination. The social workers are working with patients from different backgrounds and it requires social workers to be culturally aware when working with the patient. As part of the social work ethic, social workers need to take the initiative to ensure that they practice with cultural competence, which includes linguistic competence.

When working with patients that speaks different language, the social workers faced more than just the challenges of a language barrier. Working in a manner that is linguistically competent is complicated and requires several additional skills related to managing the client encounter when there is an interpreter in the room as well. During the session, the social workers also have to be in-tune with the interpretation in the room. The interpreters could help social workers to work with different cultural groups. However, the interpreters could also present as a challenge if they interject too much into the conversation. The social workers have to make the judgement of what is culturally appropriate for the interpreters to work with the patient.

Another social justice implication for social workers is to support the right to equal access to medical care and the avoidance of discrimination based on national origin, ethnicity, or language. By working with interpretation, the social workers are able to provide their services to a broader range of patients. Providing equal services is a basic right in the United States. These rights are also clearly protected in several state and federal laws, so social workers must be aware of these and respond accordingly. However, when working with interpretation, there are many challenges that the social workers need to be attuned to. Confidentiality could be a potential issue when working with patients and using interpretation. Patients coming from small

communities could have issues with confidentiality or privacy since the interpreters could know the patients or know people related to the patient. When a patient refuses to utilize interpretation, the social workers have to respect the self-determination of the patients even though it could be in the patient's best interest to have some sort of interpretation.

Another important finding is that over half of the respondents reported that they did not receive any training to work with interpreters even though they work in a setting where there is a high population of LEP clients. Social workers have a strong obligation to seek out skill development opportunities for working with LEP clients and for best leveraging the skills of professional language interpreters. This training gap is evident and the implications are for not only the individual medical social worker, but also for their employers and for professional social work education programs.

This exploratory study offered insights into the impact of using interpretation in practice. It will also be important for social work professionals to receive up-to-date education and training regarding the use of interpretation in their practice. In addition, the social work profession and the interpreter profession might do well to do some professional cross training so that together we are more effective in serving LEP clients. We need to have a shared understanding of not only the use of specialized vocabularies but also of each other's core competencies/ codes of ethics, roles and responsibilities.

Implication for Future Policy

Currently, there are no specific requirements in Minnesota for the training or certification of interpreters. There are no minimum standards for medical interpreters and no enforcement or oversight of interpreter health care standards in MN. This results in a wide variance in the skill levels of interpreters asked to interpret in medical and other settings. In 2015, the Minnesota

Department of Health (MDH) published a report outlining its recommendations for a tiered interpreter registry that would reflect the variation in interpreters' training and experience. The recommendation report urged the legislature to establish standards for the interpretation in health care setting with policies that did not inadvertently reduce access for some LEP client (such as those who speak rare languages and would have more difficulty finding interpreters if overly high qualification standards were enforced). From this study, interpretation has been greatly helpful in assisting healthcare providers to communicate with patients, but there are also challenges that could be eliminated if standards are established for the profession. To establish professional standards of interpretation could prevent situations where interpreter injects their own opinion or bias during the therapy process. It would also be helpful to require interpreters registered as medical interpreters to go through training to ensure the quality of interpretation. State should consider providing funding for additional training for interpreters, given that there does not seem to be enough qualified interpreters coming from outside agencies. Hospital accrediting associations, or even federal funders for hospitals and clinics (e.g. JCHO), should consider setting staffing standards compelling medical settings to employ and train more interpreters

At the agency level, there is a strong need for program managers to consider updating their policies to make it easier to access language interpreters when needed (e.g., to teach employees how to use technology to access language supports, such as telephonic and video interpretation, or to teach employees how to request the most skilled interpreters and how to coach those interpreters, and monitor quality during client sessions. Agencies may also be called upon to create new policies to accommodate the special needs of LEP clients - for example, allowing more time for each appointment when interpreters will be used, to consider adapted

ways to make appointment reminder calls to LEP clients, and to be sensitive to the transportation needs of LEP clients vs English speaking clients. Agencies need to train their staff about how to fully explain the options clients have for language access that demonstrates sensitivity to common issues such as privacy. Clients should understand the many potential negative effects of family interpretation on their care.

Implication for Future Research

At this point, it appears as though this study is consistent with previous studies regarding interpretation use in medical practice. The findings of this study give an example of current trends for interpretation use in social worker practice in a medical setting. These findings can be used as a starting point for future research regarding the use of different types of interpretation (specifically, in-person, phone, and family members/friends) and the quality of the practice. For example, one of the findings of this study was that many respondents reported that they are unsure if the interpreters are interpreting everything correctly since many times the conversation seems disjointed. In the future, it would likely prove beneficial to continue to explore this, perhaps by examining the signs of misinterpretation or how a social worker could intervene when they suspect misinterpretation is happening in the session. Researches regarding the amount and what kind of training received by social workers around working with interpretation would also be helpful to help create training and policies in the future. There are too many unknowns in the area around best practices in selecting and using spoken language interpreters with LEP clients. There is also little research that has surveyed clients and asked them how the use of interpreters has benefitted their care. It would be helpful to understand more from the patient's perspective.

Many respondents in this study reported utilizing patient's family members/ friends or bilingual staff as interpretation when working with patients. It is likely that respondents struggle to schedule interpretation, the patients declined interpretation, or there was a medical emergency with no time to wait for interpretation to arrive. It is also likely that this trend will continue so it would be important for future research to examine the confidentiality issues and understand the exact situations when it is difficult to secure interpretation. This will also be helpful for improving the social worker practice and ethics when working with interpretation. Future research will need to stay current with the use of interpretation and the impact that it has on the social work practice.

Strengths and Limitations on Current Study

There are a few strengths of this study that should be addressed. Using Qualtrics to host the survey allowed for ease and accessibility of use in order to find a greater number of respondents. Because social workers have busy schedules, this electronic survey was helpful in that respect. Also, previous literature has been used to guide the creation of the survey that was used in this study. This means that portions of the survey have been used empirically in the past. Additionally, the study focus on social workers' experiences which aimed to explore gaps in the current literature. This allowed for expansion of the social work knowledge base regarding the intersection of interpretation use and social work practice.

There are also limitations to the current study. As stated previously, this study was only exploratory. The survey responses were limited and most of the respondents work in the Twin Cities area. This means that the findings cannot truly be generalized to all social workers who work in a medical setting. Another limitation of this online survey was that there was no way to elicit more elaborate responses within the qualitative framework. If the qualitative portion had

been completed through in-person interviews, these questions could have been explained in greater depth.

Conclusion

The purpose of this research was to examine social workers' experiences and perspectives of working with interpretation in a medical setting. More specifically, the amount of different types of interpretation used along with benefits and challenges of working with interpretation were explored in-depth. The findings of this exploratory study affirmed and expanded on findings in the previous literature. As foreign born population increases in the United States, there is also an increase in spoken language interpretation used in medical settings. In-person interpretation was utilized the most out of all the different types of interpretation. Medical interpreters employed by the medical agency were favored over interpreters from outside agencies. Interestingly, the use of patients' family members and friends as interpreters is still prevalent in some situations: if patients chooses not to have interpreter present, if there is difficulty accessing interpreters, or if there is a medical emergency. The benefits of interpretation include the ability to communicate with patients, gain more cultural understanding, and increase patients' comfort and self-determination. Some of the challenges included difficulty in accessing interpretation, interpreters' own biases, boundary concerns, and issues with privacy and confidentiality. More training and education around working with interpretation would assist social workers in making ethical judgments in challenging situations. Also, more standardized policies around interpretation practice and qualification would also help avoid these challenges. As social work practice and spoken language interpretation use continue to become more integrated, there is a need for more research on the impact of interpretation in

practice, as well as how social workers can ethically and effectively manage emerging challenges.

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Appendix A

Survey Consent Form

You are invited to participate in this research project because you are a practicing medical social worker. This project is being conducted by Flora Hsu, Clinical MSW student at University of St. Thomas and St. Catherine University. The purpose of this survey is to understand the barriers and challenges face by medical social workers when working with an interpreter. This survey is asking for perspectives of working with verbal, in the moment interpretation (not deaf/ hard of hearing or document translation). The survey includes items about basic demographic, social worker practice and your experiences regarding to working with interpreters. It will take approximately 20 minutes to complete.

Your responses to this survey will be anonymous and results will be presented in a way that no one will be identifiable. Confidentiality will be maintained to the degree permitted by the technology used. Specifically, no guarantees can be made regarding the interception of data sent via the Internet by any third parties.

Your decision whether or not to participate will not affect your relationships with the researchers, your instructors, or St. Catherine University. If you decided to stop at any time you may do so. You may also skip any item that you do not want to answer. If you have any questions about this research project, please feel free to contact Flora Hsu at hsu00012@stthomas.edu or contact the faculty advisor, Lisa Kiesel at lrkiesel@stkate.edu we will be happy to answer them. If you have other questions or concerns regarding the study and would like to talk to someone other than the researcher(s), you may also contact Dr. John Schmitt, Chair of the St. Catherine University Institutional Review Board, at (651) 690-7739 or jsschmitt@stkate.edu. By responding to items on this survey you are giving us your consent to allow us to use your responses for research and educational purposes.

Appendix B

Research Survey

Part 1

Q 1. Gender- Male, Female

Q 1. Age- Text entry

Q 3. Ethnicity-

Asian or Pacific Islander
Black or African American
Hispanic or Latina
Native American or Alaska Native
White
More than one race
Other

Q 4. Language Proficiency-

English,	Poor	Fair	Good	Very Good
Other Language (Text Entry)	Poor	Fair	Good	Very Good
Other Language (Text Entry)	Poor	Fair	Good	Very Good

Q 5. Number of Years in Social Work Practice- Text entry

Q 6. Numbers of Years Working Medical Setting- Text Entry

Q 7. Size of the city of your current work setting- Large metro area, City, Town, Rural

Q 8. Licensure-

LSW, LGSW, LISW, LICSW

Q 9. Primary Task (Select as many as apply)

Psychosocial assessments
Grief and loss
End of Life Decisions/ Health Care Directives
Resources allocation/ Referral
Crisis intervention
Family issues / general legal issues as it relates to patients and families
Abuse assessments and abuse reports

Part 2

Q 10. Did you received any training regarding working with interpreters from your current work setting? – Yes or No

Q 11. How often do you use interpretation during your practice?

- Never
- Less than once a month
- Once a month
- 2-3 times a month
- Once a week
- 2-3 times a week
- Daily

Q 12. Rank the top 4 languages use by the interpreters- fill in the text boxes than rank the language by the most to least usage

- Text Entry Than rank the responses
- Text Entry
- Text Entry
- Text Entry

Q 12. When using interpreter, how often are these types of interpreters used during practice?-

Rate the following type of interpreter in Likert scale presented below

Never Rarely Sometimes Often All the time

Medical Interpreters

Interpreters from an outside agency

Q 13. When using interpretation, how often are these modes of interpretation used during practice?-

Rate the following mode of interpretation in Likert scale presented below

Never Rarely Sometimes Often All the time

In-person Interpretation

Phone Interpretation

Video Interpretation

Bilingual staff on site

Patients' family members or friends

Part 3

If the participants answer rarely or above to any of the mode above, there will be satisfaction questions in the following page of the survey

Satisfaction with () Interpretation

Rate the following statements in Likert scale presented below

Strongly Disagree Disagree Neither Agree Strongly Agree

I felt the client was at ease during the meeting

I felt the client was heard and understood me

I felt the client's privacy was respected

I felt the interpreter notice when I/ the client had problems understanding

I felt I had opportunities to ask questions

I felt the client had opportunities to ask questions

I felt the interpreter was neutral during the meeting

I felt comfortable when with the client with the interpretation

It was easy to make an appointment

I had sufficient time working with the interpreter

Part 4 Short Answer, limited to 100 words

1. What benefits do interpreters bring to your work other than interpreting the languages?
2. Does interpretation create challenges to your work? In what way?
3. Are there any situations that you would or would not talk to a patient without an interpreter?
4. What are some suggestion you have for working with interpreters?